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'Homosexuality and the medical profession: A behaviourist's view' by John Bancroft

The Scottish Minorities Group is an organization seeking to ensure the rights and welfare of homosexual men and women, and so Dr Bancroft's paper (Journal of medical ethics, 1, 176) *should be of particular interest to them.*

In their commentary on Dr Bancroft's views the authors are chiefly critical of the narrow premise from which in their opinion he writes. In their view he can satisfy neither the homosexual men and women themselves nor the psychiatrists who do not share his approach. However, they devote most of their argument to the question of the value of medical 'treatment' either to help homosexuals to keep out of legal trouble or to come to terms with their sexuality, particularly when a man or woman is uncertain of their sexual identity. Finally, they touch on Dr Bancroft's apparent misconception of the idea that homosexual organizations wish to convert men and women of ambivalent sexual attitudes to their own way of thinking.

In the second part of the paper Dr Bancroft replies briefly to their charges of misunderstanding those whom he seeks to help.

A commentary

Ruth A Schröck and Ian Dunn *The Scottish Minorities Group, Edinburgh*

Dr Bancroft's contribution to a topical debate is timely and raises issues which deserve to be closely examined. One cannot blame the author for some emotional responses which occasionally colour his argument. Homosexuality as a topic and as an experience is still surrounded by fairly intense feelings. The author sets out to consider the role that the medical profession should have in influencing public opinion, the traditional role of the doctor in helping the individual with homosexual problems, and how these two roles might interact or conflict with one another.

A classification of various types of help that could be offered by a doctor precedes the actual argument usefully clarifying Bancroft's approach. Further clarification, however, is needed to help a medical practitioner to develop some criteria by which he could define 'certain aspects of his [the homosexual's] behaviour which would otherwise get him into trouble with the law.' Depending on the doctor's acceptance of the Scottish law under which all homosexual acts between men remain a criminal offence, he would find it more or less difficult to fulfil his role in influencing public opinion in the direction advocated by the author. Neither is the Sexual Offences Act 1967 for England and Wales very definite in guiding a doctor sufficiently when he attempts to help a patient to express his or her homosexuality within the limits of the law (Fairbairn, 1974). It seems necessary to point out clearly that most advice and help offered by doctors or other counselling agents must be based on the adviser's subjective moral decisions.

Bancroft provides a brief account of public attitudes towards homosexuality to help the reader to understand the criticisms now levelled at the medical practitioner who attempts to treat homosexuality. He cites evidence for the kind of attack directed at psychiatrists by homosexual organizations but he confines the source material to one publication. The named pamphlet may or may not be representative of the arguments but it would have been more convincing and might have illustrated what the argument is all about, if evidence had been provided from a greater range of publications (undated pamphlets by Blamires and by Karlen). It should also have been made clearer that criticism of medical intervention in this area does not only come from homosexual organizations, which could be considered to express biased preferences as to how they would like doctors to respond to the needs of homosexual women and men, but that some medical practitioners are themselves critical of some current medical treatment of homosexuals (Ramsay *et al*, 1974; Weinberg, 1974). But in discussing the present situation Bancroft raises certain important questions which are not all equally well documented or argued.

Defining the need for treatment

A fundamental task in any health care situation is the definition of need or of the patient's motive for seeking treatment and the decision whether available methods of treatment offer a realistic promise of success. Bancroft does not deal in depth with the question of how a doctor would establish the need for treatment or what motivation of the person seeking help would be indicative that treatment is needed and likely to be successful. In this context

it is again not very clear what 'less controlled or socially dangerous aspects of their [the homosexuals'] sexuality' are. Neither is there any explanation why some homosexuals wish to become heterosexual. As a global statement this leaves much to the subjective interpretation of the reader. He does, however, point out that one can postulate the necessity for all homosexuals to be treated (or their responsibility to seek treatment) if it can be shown that medical intervention is effective. He also admits that this logical implication is still a threat to homosexual freedom. He may well be right in claiming that most doctors would reject this conclusion but he cannot really expect that his assertion alone would remove the fears of homosexual women and men which arise precisely because the unqualified postulate, as it stands, is a perfectly logical one.

Establishing a sexual identity

Bancroft sees a need for medical intervention when a person is uncertain of his or her sexual orientation and is still searching for an appropriate, individually satisfying self image. There is no reason for any disagreement with the suggestion that psychological help in these circumstances could be of considerable value. But it is here that the author could have made a clear distinction which might have solved some of the anxiety-provoking implications that homosexuals should seek treatment. It does seem important to distinguish between treatment of homosexuals and medical help for people who are uncertain of their sexuality. This may not have been an intentional confusion but the central issue might have become clearer if the author had not repeatedly emphasized the homosexual's need or wish for treatment in order to curb less controlled or socially dangerous aspects of sexual behaviour. This and the problems created for individuals through lack of certainty of their sexual orientation are two different questions and deserve separate arguments. The problems of defining the possible needs of the individual are quite different. Uncertainty about anything is largely a definition of an individual's state of mind arrived at by the person who feels uncertain; defining a person's behaviour as unacceptable or dangerous is usually an action by other people in a social context. This is only one difference that might call for separate arguments. The literature of the homosexual organizations provides some evidence that their criticisms against psychiatry concentrate largely on the issue of social control by medical treatment and are not directed against medical practitioners who deal with difficulties of sexual identification. Bancroft disputes this on the basis of one American publication (Karpman, 1954) and also maintains that there is 'hostility to the increasing acceptance of bisexuality in certain subcultures' in homosexual organisations. A perusal of the only British fortnightly paper, *Gay News*, that is concerned with a serious coverage of the events, experiences, attitudes and opinions in the homosexual situation yields the impression that the commoner response of homosexual people to those who are trying to develop a bisexual identity is uncertainty rather than hostility.

Distinction between treatment and learning

The problems attending an individual's sexual uncertainty raise another point which Bancroft does not explore sufficiently. He does attempt to distinguish between treatment and learning. This distinction may not be too easily apprehended if both processes are taking place within the framework set by the medical model. To most lay people, including those who are homosexual or in search of their sexual identity, a behaviour therapist, whether psychologist or psychiatrist, appears to be a medical practitioner of some kind, even if this possibly mistaken impression may only be created by the fact that a good many behaviour therapists practise in the environs of some psychiatric setting. But more important may be the fact that all psychological methods of treatment, or all processes of learning for that matter, must be directed to some goal. Since, by definition, the person who is uncertain of his or her sexual identity cannot provide such a goal in partnership with the therapist, the therapist must select the goal he feels to be most suitable for his patient. One may argue, of course, that any goal setting should be preceded by a process of exploration and non-directive counselling, but this would surely raise the question of where the specific skills of the behaviour therapist came into play.

Pressures for conversion

Bancroft is, quite rightly, concerned with the possible eagerness homosexual organizations might exhibit in converting the undecided individual to adopt a homosexual life style. He again, unfortunately, bases his conviction that this is, indeed, the aim of homosexual groups on his acquaintance with a very narrow range of literature (*Growing up Homosexual*, 1974). Of greater significance is the fact that the author does not seem aware of the possibility that the same, possibly unconscious eagerness for conversion, may arise from the life experiences of the heterosexual therapist. It is a well known phenomenon in all areas of human experience that man considers desirable for others what he values and what he knows by his own experience to have given him fulfilment and satisfaction. The examples from other fields of human endeavour are endless. The fairly topical criticism of middle-class values in western European society which are set up as the desirable norm for countless other so-called subcultures may serve as an example here.

This situation, from whichever side one looks at

it, poses a real dilemma, since one cannot reasonably expect to find individuals free of any values in any society. The conscious acceptance of the risk of guiding other people's choices in the direction preferred by the professional counseller or therapist might avert the greater danger of a subconscious selection of goals thought suitable and valuable by the adviser.

Due to the not very clear distinction between treatment for homosexuality (or certain aspects of it) and counselling the sexually confused, one is also not quite sure to which area of professional activity the author's claim of the effectiveness of behaviour therapy techniques relates. Counselling (and protecting) the person who is unsure seems to demand a range of interpersonal skills which are not unique to behaviour therapists but are shared by a fair range of professional groups. The possible claim to the effectiveness of changing homosexual behaviour patterns into heterosexual ones merits wider discussion than the author allows in this instance.

This is not the place to elaborate on and to seek agreement on the published studies which may or may not allow the claim of effectiveness, but it would have served the reader well to be reminded in the words of a behaviour therapist that 'there is still a great paucity of sound and critical evidence and many of the studies leave much to be desired both in design and control' (Meyer, 1969).

We, throughout this commentary, include both homosexual men and women in our discussion. Bancroft does not refer to or consider female homosexuality at all. It is important to know whether this omission arises from the fact that the author has not encountered women as patients which might be significant in evaluating the homosexual experience, or whether the quest for a sexual identity is seen as a problem only related to men. Perhaps one step towards understanding homosexuality is to see it as a human experience.

'In an emotive area such as this there is much scope for misunderstanding' are Bancroft's closing words. We hope that this commentary, attempting clarification and discussion, has contributed a little towards lessening some of the possible misunderstandings.

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Dr Bancroft replies

John Bancroft *University of Oxford*

Ruth Schröck and Ian Dunn make a number of valid points but they have also misunderstood some of the article and I will therefore attempt further clarification of a few issues.

Throughout the article I explicitly distinguish between, on the one hand, help for those who wish to explore heterosexual relationships or resolve uncertainties about their sexual identity, and on the other hand those who seek help to control their sexual behaviour which might otherwise get them into trouble with the law. There should be no confusion between these two. However, with the first, I do not see it as either possible or necessary to do as they suggest and distinguish between 'treatment of homosexuals and people who are uncertain of their sexuality'. Clearly there are extremes but in between lies very much a continuum.

It is true that in commenting on help to avoid conflict with the law, I had in mind the English and not the Scottish law. In practice this is not important, however, for reasons given in the legal article that they cite. It is not the doctor's role in this respect to facilitate implementation of the law but rather to help the patient or client who wants to keep out of trouble. For example, I happen to believe that the age of consent should be the same for homosexual and heterosexual acts. That in itself is not likely to help my patient, with the English law in its present form; on the other hand, I may be able to help him to minimize the risk of being prosecuted.

Of course people seek help to curb the less controlled or socially dangerous aspects of their sexuality. Homosexual behaviour is involved in only a proportion of such people and obviously for the vast majority of homosexual relationships no such help is required or sought. Some individuals have an enormous amount to lose if their exceedingly risky behaviour, often in public places, leads to prosecution. In some such cases it is risk taking itself which is an important part of the motivation though that is not likely to become clear without therapeutic involvement.

Whilst I accept that many homosexuals have more moderate views about medical help than those referred to in my article, it is the more militant who are inevitably more vocal and thus have an influence which provokes counter. It is suggested that only 'social control' produces criticism. Unfortunately many attempts to help the individual who genuinely seeks change are labelled as 'social control' on the grounds that the individual does not of his own free will seek such help, but does so because of social pressures to conform. As I wrote in my article there is no logical counter to such a view.

I appreciate that help given in a medical setting is likely to be seen as medical treatment of illness. That is a reason for writing such articles as mine, not for withdrawing the help. The suggestion that the effectiveness of medical intervention leads logically to the necessity for all homosexuals to receive such intervention is a puzzling one. In no way is this a 'logical postulate' nor would it be seen to be from the way I presented it.

In their comments, Schröck and Dunn reveal some of the misunderstandings of the behavioural approach which I was hoping to rectify in my article. It is true that the therapist is often in a position to impose his own values onto his patient. Once again that is a reason for exercising caution rather than for withholding help. I would prefer not to have a situation in which professional helpers were themselves free of values. I am aware that I value sex as a means of binding interpersonal relationships and facilitating communication. I admit to some prejudice against sex that is divorced from interpersonal relationships.

Of course there are approaches to counselling other than the behavioural. With recent developments in sex counselling it is becoming increasingly obvious that there is much overlap between different approaches, including the behavioural.

The question of the efficacy of behavioural techniques is raised. In fact I made no claims in this respect in my article. The evidence for the efficacy of earlier behavioural techniques was very closely scrutinized in my book and found wanting. The behavioural approach to counselling has come a long way from its early origins; techniques are now less important than the overall approach and basic principles that are used.

Finally let me make it clear that I was writing about homosexuality in general rather than male homosexuality. I can see that it would have helped to have made that point explicit. With the very best of intentions it is extremely difficult to write concisely on this subject without being misinterpreted or misunderstood to some extent. I am grateful therefore to Ruth Schröck and Ian Dunn for giving me this further opportunity to clarify some issues.